Health Care Financing Administration

MEDICAID FRAUD & ABUSE COMMITMENT CONFERENCE

SUMMARY REPORT

BACKGROUND

The Health Care Financing Administration's National Medicaid Fraud and Abuse Initiative, under contractual arrangement with Dr. Malcolm Sparrow of Harvard University's Kennedy School of Government, conducted a series of four Executive Seminars around the country in 1999. This project was another effort to continue to build and sustain a strong State-Federal partnership to address the problem of fraud and abuse in the Medicaid program. These seminars were designed to share innovations, to identify obstacles and challenges, and to provide State officials with additional tools and strategies in their efforts to combat and control fraud and abuse in their Medicaid programs. High level representatives from 49 States and numerous Federal agencies and Departments participated. At the conclusion of the seminars, Dr. Sparrow produced a summary report entitled, "Controlling Fraud and Abuse in Medicaid: Innovations and Obstacles," which was subsequently distributed to all State Medicaid Directors, as well as all State and Federal participants.

Dr. Sparrow's summary report contains a wealth of information about the States' efforts to control fraud and abuse in the Medicaid program, and it served as the primary resource document for the Commitment Conference. The one-day conference was designed to achieve a number of goals. The core goal was to convene State decision-makers and relevant Federal program and law enforcement officials to discuss the ideas and concerns presented by the States at the four seminars, and to put new ideas and strategies "on the table." Secondly, the conference was intended to serve as a forum for interstate and State-Federal information exchange as a means of better understanding roles and the challenges faced at the State level. Finally, it was intended to strengthen the State-Federal partnership and commitment to pursue future collaborative efforts and projects.

Responses to the conference evaluation indicate that the vast majority of participants felt that the primary goals were met. Detailed results of the evaluations can be found at the end of this report. Many excellent ideas as well as proven and potential strategies were discussed, evaluated, and refined in the course of the day. A summary of the results is outlined below.

RESOURCE COMMITMENT

One of the primary items of discussion was how to increase the level of resources devoted to fraud and abuse and program integrity work in the State. One Federal participant asked if States would increase their resource commitment if HCFA imposed a higher level of requirements. States generally opposed this idea, indicating that it would engender a negative reaction on the part of Governors and State legislatures and, would ultimately, prove counterproductive.

Incentives were another major subject of discussion. One participant suggested that incentives should be based on performance, i.e., tie FFP levels to performance. Some State participants expressed concern that this could adversely affect funds available for providing the same or increased levels of services to program beneficiaries. A few States, however, saw significant potential for increasing the level of services offered.

One Federal participant questioned why States need additional incentives to obtain support from State leadership and legislatures since effective fraud control is a matter of self-interest. A number of States responded by saying that provider influence is particularly strong at the State level. States indicated that this creates more disincentives than incentives to finding fraud in the program. The consequences of finding fraud can be negative; the "messenger" is more often shot than rewarded for exposing fraud. In fact, Dr. Sparrow points out that this is a fairly common reaction in the first chapter of his book, License to Steal: Why Fraud Plagues America's Health Care System.

Another reason given in support of incentives was the fact that fraud and abuse always comes out second when the choice is between allocating resources for additional services or increasing fraud and abuse activity.

A number of States indicated that there was a need for better, more targeted data, which would pinpoint areas most likely to foster fraud. This kind of information could be used to draw attention to the need for increased resources. Accurate measurement at the State level could make a compelling case for both education of legislative and executive office staff, and encourage greater support of anti-fraud efforts from political circles.

MEASUREMENT

One of the Federal participants argued for the use of measurement, e.g., using error rate studies, similar to those conducted in the Medicare program, as an essential method for identifying and gauging the extent of the fraud and abuse. The basic point was that you cannot effectively attack a problem if you do not know the true extent of the problem. A number of States expressed concerns similar to those noted above, i.e., local political fallout, the "shoot the messenger" syndrome, and the cost and labor intensity involved in conducting such studies. Other States questioned how error rate

measurement could prove their effectiveness in terms of prevention and deterrence. However, some States acknowledged the potential benefits of measurement, both in a pure operational sense and in terms of obtaining additional support.

Some of the discussion about measurement revolved around providing incentives to States to experiment, not unlike demonstrations that have been undertaken in other programmatic areas. One Federal participant suggested the possibility of providing Federal grants to States willing to conduct measurement studies. Some State interest was expressed in this type of approach. This would address the funding problems associated with conducting such studies. The “shoot the messenger” syndrome remains problematic.

One State suggested that if measurement was the goal, it made sense to do targeted error rate studies, rather than taking a generalized, across-the-board approach. This would help to quantify the problem in known, or long suspected, problem areas of the program. This kind of documented information could then be leveraged to obtain additional support and resources without the potential political fallout from an overall error rate.

INFORMATION EXCHANGE/TECHNOLOGY

A discussion about the need to increase information sharing between Medicare and Medicaid resulted in a consensus that these efforts should continue, mainly through the Medicaid Fraud and Abuse Technical Advisory Group (TAG).

States indicated there was a need to address apparent inconsistencies in the approved Federal match rate for systems between regions. When States compared notes and experiences, it appeared that different rules and standards were being applied by HCFA in different regions when approving fraud and abuse detection systems. For example, some systems were approved at the enhanced match rate of 75 percent Federal Financial Participation (FFP), while others were only approved at the regular administrative match rate of 50 percent FFP.

There was extensive discussion about the Technology Conference that HCFA, in collaboration with DOJ, is sponsoring in late June. A number of States indicated that a comparative analysis of the different vendors' systems would be of great use. A Federal participant indicated that HCFA is using a new statistical analysis contractor in a technical assessment function. The possibility of applying this technical assessment function to develop test data to compare relative merits of different vendor products was discussed. Most States indicated that they found this an exciting possibility. As a starting point, Federal participants committed to follow-up on the Technology Conference and to use the interagency committee as a liaison to provide information on emerging technologies to the States.

LEGISLATION

The Counsel to the House Commerce Committee's Subcommittee on Oversight and Investigations solicited direct input from States on what types of legislation would best support their anti-fraud efforts. A number of State participants cited the inconsistent Federal matching levels (75 percent or SURS and MFCUs, 50 percent for general fraud and abuse) as an impediment. Others indicated that the 60-day rule, from a State point of view, provided a disincentive to identifying and reporting overpayments because the rule requires repayment of the Federal share 60 days after discovery vs. 60 days after recovery. The representative from the House Commerce Committee indicated that there would be legislation to address this. One of the Federal participants asked if the proposed modification to the 60-day rule applied to overpayments derived directly from fraudulent activities or to all overpayments. The Counsel indicated that it would apply to overpayments identified as a direct result of fraudulent practices. The Counsel also indicated that the Subcommittee hoped to have legislation written by late July and offered the States a unique opportunity: He provided his phone number and e-mail address and invited the States to provide the Subcommittee with their ideas and suggestions for possible legislative changes no later than July 1, 2000.

MANAGED CARE

Managed Care was another topic that generated active discussion, both at the Executive Seminars and at this conference. The representative from the National Association of Medicaid Fraud Control Units (NAMFCU) indicated that they have created model criminal and civil statutes that could be found on the NAMFCU's web site. It was suggested that these documents might be linked to the HCFA Medicaid Fraud Statutes web site.

Significant discussions centered on the role of contracts in the managed care setting and the need to improve contracting processes and the quality of contracts. It was generally agreed that the key to fraud control resides with the contract. One of the Federal participants reminded the States that HCFA, through a contract with George Washington University's Center for Health Policy Research, organized a series of five workshops almost 4 years ago. These workshops focused on the contracting process and virtually all SURS and MFCU Directors attended. It was suggested that the time might be right to repeat the workshops, combining contracting with specific fraud control experiences, techniques and methods.

States requested that HCFA continue to provide "Best Practices" for all areas related to fraud and abuse, specifically managed care.

With the release of the Guidelines for Addressing Fraud in Medicaid Managed Care, the States will have a substantive, comprehensive and usable document that lays out in

detail the key components of an effective managed care fraud and abuse prevention and detection program.

EVALUATION

As noted earlier, most participants reacted very favorably to the conference. Satisfaction ratings ranged from 90% to 100% in the key areas of evaluation:

➲ Findings in the Sparrow Summary Report are clear and useful to State's efforts to control fraud and abuse

➲ Participants will strongly support the implementation of strategies identified during conference

➲ Facilitation was effective in achieving conference objectives

➲ Satisfied with my participation in today's conference

CONCLUSION

The primary objectives of the conference, outlined in the introduction to this report, were met. Many ideas were put forward and most participants came away with a better understanding of challenges and pressures facing both the States and Federal agencies. In addition, the conference further strengthened the State-Federal partnership. The ideas developed at the conference will be forwarded to the Medicaid Fraud and Abuse Technical Advisory Group (TAG) for their consideration and follow-up.

The conference laid the groundwork for future collaborative State-Federal efforts, perhaps in the form of workgroups, special projects, or some other joint activity.

SUMMARY OF PROPOSED FUTURE ACTIONS

Resource Commitment

➢ Explore potential incentives to States to help increase the level of resources devoted to fraud and abuse. – **HCFA, OIG**

Error Measurement

➢ Develop subgroup of Medicaid Fraud and Abuse Control TAG to explore feasibility of State error measurement. – **HCFA, States**

Information Exchange/Technology

- Medicaid Fraud and Abuse Control TAG should continue working with Medicare to increase information sharing. **- HCFA, States**

- Address inconsistencies in approved Federal match rate for fraud and abuse systems enhancements. **- HCFA**

- Assess feasibility of using HCFA 's statistical analysis contractor to develop test data to compare relevant merit of vendors' products. **- HCFA**

Legislation

- States should submit suggestions for legislative changes to House Commerce Committee. **- States**

Managed Care

- Link NAMFCU model criminal and civil statutes to HCFA Medicaid Fraud Statutes web site. **- HCFA, NAMFCU**

- Assess feasibility of managed care workshops which combine contracting with specific fraud control experiences, techniques and methods. **- HCFA, DOJ, OIG**

- Distribute "Guidelines for Addressing Fraud in Medicaid Managed Care" to conference participants upon official release.**- HCFA**